TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Courtney Eckelkamp, D.C.

Respondent Name
New Hampshire Insurance Company

MFDR Tracking Number
M4-17-0620-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
November 3, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per DWC Rule 134.204 (2) (C) if the examining doctor determines MMI has been reached and an IR evaluation has been performed both the MMI evaluation and the IR evaluation portions of the examination shall be billed and reimbursed. For maximum medical improvement examination the examining doctor other than the treating doctor shall bill and be reimbursed $350.00…

The attached claim was billed based on DWC Rule **134.204 (i) (4) (C) (ii)** regarding Designated Doctor Examinations as it applies for billing and reimbursement of an IR (Impairment Rating) evaluation … The rule indicates 'if a full physical evaluation WITH RANGE OF MOTION IS PERFORMED the MAR shall be $300.00 for the first musculoskeletal body area and $150.00 for each additional musculoskeletal body area.

Therefore, per the original report submitted with this claim, you will note a 'full physical evaluation with range of motion was performed' and was included in the explanation of the impairment rating in the report …"

Amount in Dispute: $315.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see the EOB(s) and the reduction rationale(s) stated therein. This is a fee schedule reduction."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 17, 2016	Designated Doctor Examination	$300.00	$300.00
June 17, 2016	Work Status Report	$15.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services from March 1, 2008 until September 1, 2016.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - 4150 – An allowance has been paid for a designated doctor examination as outlined in 134.204(j) for attainment of maximum medical improvement. An additional allowance may be payable if a determination of the impairment caused by the compensable injury was also performed.
   - 309 – The charge for this procedure exceeds the fee schedule allowance.
   - 4151 – An allowance was not paid for the work status report. Reimbursement to RME doctors and designated doctors for the report is included in the reimbursement for the examination.

Issues

1. What is the dispute in question?
2. What is the maximum allowable reimbursement (MAR) for the disputed services?
3. Is Courtney Eckelkamp, D.C. entitled to additional reimbursement?

Findings

1. Courtney Eckelkamp, D.C. submitted a Medical Fee Dispute Resolution Request (DWC060) that included procedure codes 99456-W5-WP, 99456-W8-RE, and 99080-73. However, Dr. Eckelkamp is seeking $0.00 for procedure code 99456-W8-RE. Therefore, this procedure code will not be considered for this dispute. The division finds that the dispute in question is for reimbursement of $315.00 for a Designated Doctor Examination and Work Status Report represented by procedure codes 99456-W5-WP and 99080-73.

2. Per 28 Texas Administrative Code §134.204(j)(3), "The following applies for billing and reimbursement of an MMI evaluation… (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." The submitted documentation supports that the requestor performed an evaluation of Maximum Medical Improvement. Therefore, the correct MAR for this examination is $350.00.

   Per 28 Texas Administrative Code §134.204(j)(4), "The following applies for billing and reimbursement of an IR evaluation. … (C)(ii) The MAR for musculoskeletal body areas shall be as follows. … (II) If full physical evaluation, with range of motion, is performed: (-a-) $300 for the first musculoskeletal body area." The submitted documentation supports that the requestor provided an impairment rating, which included a musculoskeletal body part, and performed a full physical evaluation with range of motion of the right wrist. Therefore, the correct MAR for this examination is $300.00.

   Per 28 Texas Administrative Code §134.204(l), "The following shall apply to Work Status Reports. When billing for a Work Status Report **that is not conducted as a part of the examinations outlined in subsections (i) and (j) of this section** [emphasis added], refer to §129.5 of this title (relating to Work Status Reports)". Therefore, the filing of the DWC-073 is not separately payable when provided in conjunction with a Designated Doctor Examination performed according to 28 Texas Administrative Code §134.204(i).

3. The total MAR for the services in question is $650.00. The insurance carrier paid $350.00. The division finds that an additional reimbursement of $300.00 is due.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $300.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $300.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	December 5, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.